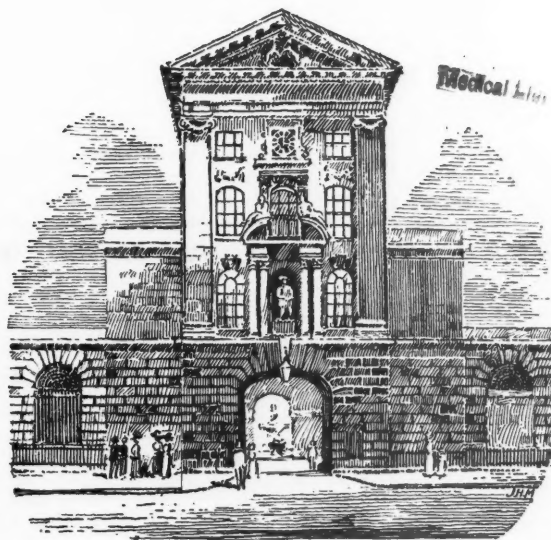


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ST BARTHOLOMEW'S HOSPITAL JOURNAL



VOL XXXVI.—No. 5.

FEBRUARY, 1929.

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CONTENTS.

	PAGE		PAGE
Calendar	65	Students' Union :	
Editorial Notes	65	Rugby Football Club	77
Obituary :		Hockey Club	77
Mr. J. Acton Davis	66	Correspondence	78
H. V. Burt	66	Reviews	78
The Mind and How it Works. By Sir		Books Received	79
Robert Armstrong-Jones, C.B.E., M.D.,		Acknowledgments	79
D.L.	67	Examinations, etc.	80
An Indication for Ventriculography. By		Changes of Address	80
J. P. Ross, M.S., F.R.C.S.	70	Births	80
Duodenal Ulceration : An Historical Survey,		Marriages	80
with a Record of an Unusual Case.		Deaths	80
By A. H. T. Robb-Smith	72	Index to Advertisements	ii
The Busy Bees of St. Bartholomew's			
Hospital	75		
Arms and the Man. By E. D. M.	75		

INDEX TO ADVERTISEMENTS.

		PAGE			PAGE			
Allen & Hanburys Ltd.	Ophthalmoscope	...	...	Hall & Sons, Ltd.	"Ideal" Boots and Shoes	...	...	v
Alliance Drug and Chemical Co.		...	...	Maw, Son & Sons, Ltd.	"Tensile" Glove	...	...	vii
Angier's Emulsion		...	...	Medical Sickness, Annuity and Life Assurance Society, Ltd.		...	...	xi
Benger's	Food	...	...	Millikin & Lawley	Microscopes, Instruments, etc.	...	...	ii
Books—		...	...	Northwoods, Winterbourne, Bristol		...	...	iv
Adlard & Son, Limited	The Fundus Oculi	...	...	Paripan, Ltd.		...	...	xi
Baillière, Tindall & Cox	The Puerperium	...	...	Parke, Davis & Co.	' Pitocin '	...	...	vi
Heath, C. J.	Otitis Media	...	...	Ronuk		...	...	ii
Gregg Publishing Co.		...	...	Royal Naval Medical Service		...	...	iv
Gunter, F. E.	Tuberculin in Practice	...	...	Shepherd, A.	Tailor and Hosier	...	...	iv
Lewis & Co. Ltd.	Publications	...	...	St. Bartholomew's Hospital		...	...
Boots Pure Drug Co. Ltd.	" Bismostab "	...	...	Medical College	Preliminary Scientific Department	...	...	viii
Clinical Research Department of St. Bartholomew's Hospital		...	...	Ditto	Scholarships; Bacteriology	...	...	viii
Down Bros.	Specialities	...	...	Ditto	Fellowship Classes; Entrance Scholarships	...	...	ix
Evans & Witt	Booksellers, Stationers, etc.	St. Bartholomew's Trained Nurses' Institution		iv
Gieves, Ltd.	Royal Naval Medical Service	Virol		vi

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"Æquam memento rebus in arduis
Servare mentem."
—Horace, Book ii, Ode iii.

JOURNAL.

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FEBRUARY 1ST, 1929.

PRICE NINEPENCE.

CALENDAR.

- Fri., Feb. 1.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
Medicine: Clinical Lecture by Sir Thomas Horder.
- Sat., " 2.—Rugby Match *v.* Devonport Services. Home.
Association Match *v.* Old Chalmelians. Away.
Hockey Match *v.* R.N. Chatham. Away.
- Mon., " 4.—Special Subject: Clinical Lecture by Mr. Elmslie
- Tues., " 5.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Debating Society.—At 8.30 p.m. in the Medical and Surgical Theatre: **Joint Debate with the Royal Free Hospital.**
- Wed., " 6.—Surgery: Clinical Lecture by Mr. L. B. Rawling.
- Fri., " 8.—Prof. Fraser and Prof. Gask on duty.
Medicine: Clinical Lecture by Dr. Morley Fletcher.
- Sat., " 9.—Rugby Match *v.* Glamorgan Wanderers. Home.
Association Match *v.* Old Malvernians. Home.
Hockey Match *v.* R.M.C., Sandhurst. Away.
- Mon., " 11.—Special Subject: Clinical Lecture by Mr. Rose.
- Tues., " 12.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
- Wed., " 13.—Surgery: Clinical Lecture by Sir C. Gordon-Watson.
Hockey Match *v.* Keble College, Oxford. Away.
- Thurs., " 14.—**Abernethian Society.**—Address by Dr. Harrison.
- Fri., " 15.—Sir Percival Hartley and Mr. L. B. Rawling on duty.
Medicine: Clinical Lecture by Sir Percival Hartley.
- Sat., " 16.—Rugby Match *v.* O.M.T.'s. Home.
Association Match *v.* Old Bradfieldians. Home.
Hockey Match *v.* R.E., Chatham. Away.
- Mon., " 18.—Special Subject: Clinical Lecture by Mr. Elmslie.
- Tues., " 19.—Sir Thomas Horder and Sir C. Gordon-Watson on duty.
- Wed., " 20.—Surgery: Clinical Lecture by Sir Holburt Waring.
Hockey Match *v.* Epsom College. Home.
- Thurs., " 21.—**Last day for receiving matter for the March issue of the Journal.**
- Fri., " 22.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Medicine: Clinical Lecture by Sir Thomas Horder.
- Sat., " 23.—Rugby Match *v.* London Welsh. Away.
Association Match *v.* Keble College, Oxford. Home.
Hockey Match *v.* Mill Hill. Away.
- Mon., " 25.—Special Subject: Clinical Lecture by Mr. Scott.
- Tues., " 26.—Prof. Fraser and Prof. Gask on duty.
- Wed., " 27.—Surgery: Clinical Lecture by Mr. L. B. Rawling.

EDITORIAL.

THE members of the Royal Hospital of St. Bartholomew's have watched with unabated interest the progress of their Royal Patron, His Majesty the King, and have eagerly looked for the admirable bulletins of his advisors, and earnestly hope for a full restoration to health.

The daily papers have recently waxed (according to the colour of their various opinions) indignant or amused over the question of the admission of women students to the London schools of medicine. Perhaps the discussion has been a little acrid because the hospitals concerned are those which admitted women to their schools about the time of the war, and later decided to admit no more. It may be that such *volte faces* were thought to be the traditional privilege of the sex which sought, not the sex denying admission.

St. Bartholomew's, always the stronghold of men, and the London School of Medicine for Women, equally unisexed, are qualified as combatants in the question upon which the matter ultimately turns—the admission of women to the medical profession. The admission is a fact, but the denial of a London training or of a training at any of the great provincial schools of medicine unpleasantly curbs the progress of feminine practitioners.

"That the entrance of women into medicine has been of benefit to the medical profession and to the general public" is to be debated at St. Bartholomew's Hospital on February 5th. Members of the Royal Free are proposing, and members of this Hospital opposing the motion.

The London School of Medicine and the Nursing Staff have been invited; mere force of numbers will have no value in this aspect of the sex war—or rather, argument. Sir Thomas Horder will take the Chair.

We understand that a reciprocity scheme between

the East London Hospital for Children, Shadwell, and the Barnes Hospital, St. Louis, U.S.A. comes into force from January 1st, 1929, for the annual interchange of residents. Mr. Wilfred Gaisford is the first visitor from this side. We welcome the scheme as being an example of the only method—that of personal contact—which is likely to allay permanently any misunderstandings between this country and U.S.A. Moreover the scientific value to each is likely to be considerable.

* * *

On Thursday, January 17th, the new Recreation and Lecture Rooms of Queen Mary's Home for Nurses were opened by the Right Hon. the Lord Mayor. After a luncheon in the Committee Room, the Lord Mayor, accompanied by the Lady Mayoress and by the Sheriffs, was conducted across the Square to the new Rooms by Lord Stanmore. From the platform prayers were read by the Rev. Justyn Douglas, Vicar and Hospitaller. Lord Stanmore then welcomed the Lord Mayor and Lady Mayoress, saying he hoped it would be the first of many visits. Having received the key from the Architect, Mr. Matthews, F.R.I.B.A., O.B.E., declared the new rooms open.

The ground floor contains a sitting-room (40 ft. square) for the staff nurses, a sitting-room (26 ft. square) for the probationers, and a library, which is to be known as the Isla Stewart Memorial. There is in addition a lecture, a class and a medical record room. The rooms are beautifully appointed, and are perfect backgrounds for the recreation of a nurse surfeited with "hospital."

* * *

The Asiatic's use of the English language has now become a tradition. Seldom has it been our delight to be sent an example of such magnificent misuse of the language as that of a gentlemen in this letter to an M.O. in India:

Respectively herewith

That your humble petitioner is a poor man in agricultural behaviour and much depends on seasons for the staff of life and therefore he falls upon his family's bended knees and implores of the merciful consideration for a damnable miserable like your honours humble petitioner was too poorly during last rains and was trying vernacular medicines without effectuality, was resuscitated by much medicines of Dr. J. Lazarus which made magnificent excavations in the coffers of your humble servant.

That your humble petitioner has large family consisting of seven lives, two males, five females, last of whom in milking parental mother and is very noiseful through pulmonary catastrophe in the interior abdomen and another birth is through Grace of God shortly accruing to wife of bosom.

That your humble petitioner prays that if there is a place ever so small in the back of your benevolence this slave be allowed to creep in. For this act of kindness he shall as in duty bound ever pray for your honours longevity and procreateness.

RAMONATA LAL.

* * *

The Warden requests us to state that the closing date for applications for House Appointments in May is 12 noon, Saturday, February 16th, 1929.

OBITUARY.

MR. J. ACTON DAVIS.

IT is with much regret that we announce the death on January 22nd of Mr. George Acton Davis, J.P., in his eighty-third year.

Despite his extensive interests in the City—he was the *doyen* of life assurance chairmen—he found time to be one of the most valuable and generous helpers that St. Bartholomew's has ever had. Elected a Governor in 1886, he served in the course of forty years on every Committee of the Hospital. In July, 1912, he became Acting Treasurer for Lord Sandhurst, who was then Lord Chamberlain, and this arduous position he occupied until October, 1915. From 1919 until his death he was Chairman of the Finance Committee.

On his retirement from the Acting Treasurership the following resolution was passed at a Court of Governors:

"That this Court hereby records its unqualified appreciation of the very able manner in which Mr. George Acton Davis has presided over the affairs of the Hospital for the past three and a quarter years.

"In the discharge of the duties of the office of Acting Treasurer, which he is now relinquishing, Mr. Acton Davis has given generously of his time, while his special knowledge and experience have been of the greatest advantage to the Hospital in dealing with the many important questions which have arisen during his administration.

"That this Court is deeply sensible of its indebtedness to Mr. Acton Davis, and tenders him its most cordial and grateful thanks for his devotion to the welfare of the Institution."

H. V. BURT.

We regret to announce the untimely death of H. V. Burt, a shock to the many who were fortunate enough to know him.

Burt entered Sandhurst in 1907 from Clifton College, and was then transferred to an Indian cavalry regiment—serving throughout the war in India—and retiring with the rank of Captain at the end of the war.

He entered the Medical College in 1924, and was nearing qualification when his death occurred.

He was Financial Secretary to the Students' Union, and an enthusiastic and distinguished member, both of the United Hospitals Yacht Club, and of the Hospital Golf Team, of which latter he was Secretary.

He displayed the same keenness in his work as well as in his recreation, and he was as sound as he was keen.

He was, moreover, a delightful companion, a man whom it was a pleasure to be associated with, and his absence will be deeply felt by all.

THE MIND AND HOW IT WORKS.

An Address delivered to the Abernethian Society.

ICAN assume it to be true that the aim of all reasonable human beings is to add to their happiness, by seeking that which is beneficial to their interests and avoiding that which is harmful, and that all of us here to-night wish to succeed and to rise to positions of dignity or of comfort or social fame; in other words, to attain full self-realization.

It is claimed that Man is the commander-in-chief of his own mental forces; therefore he should know something about them, and it behoves him also to keep his forces alert and active. Pope said that the proper study of mankind is man, and Sir William Hamilton further added—"On earth (says an ancient philosopher) there is nothing great but man; in man, there is nothing great but mind" (*Lectures on Metaphysics and Logic*, vol. i, p. 24).

The living body of man has been described as a little world set in the midst of a larger world, and although man is very much the same outwardly as he was 5-6000 years ago, in the time of Moses, yet his environment has completely changed, which is due to his mind, and recently the increasing recognition of mind problems, together with the added interest in psychology, have induced me to ask the question, "How does the mind work?" and to endeavour to place the answer before you, for to no other persons in the community are facts connected with the mind of more importance than of the doctor, the nurse and the social worker.

The senses have quite properly been regarded as supplying the necessary material to form the mind, and for this reason the senses have been called the windows of the mind. They are undoubtedly the main avenues to the mind, and it is usually taught that we have five of them; but the number is much more than five. It is probably twenty at least, *i.e.* if we include those relating to hunger, thirst and the appetites; for in touch we have the four skin sensations of pure touch, heat and cold as well as pain receptors, each provided with a separate end-organ, and even pure touch may be regarded as of four more kinds, *viz.* those for the deep muscles, those for the tendons, for the ligaments, and also those for the joints. In the sense of taste we have at least four varieties, *viz.* sweet and bitter, acid and salt. In hearing we have two, *viz.* sound and the

sense of position, or of static equilibrium through the semi-circular canals. We know how sounds may sometimes make us jump. To neurasthenic persons the ticking of the clock may cause distress, to them the doors shut with a louder bang, the cinders fall on the hearth with a heavier thud, and the cups and plates clatter so that a nervous person hearing them may even jump out of bed. Noises excite and annoy, disturb and distress not so much by sound effects as by their jarring vibrations, which—even when the mind is subconsciously asleep—are conveyed to the brain by the vestibular nerves. Further, there is the sense of sight, which enables us both to see colours and to appreciate light and shade—itsself thus a double sense. Moreover there is the power, through pupillary accommodation, to judge distances. There is also the sense of smell, the oldest sense, and called the sense "to get and to beget," which is able to furnish the mind with much information. If our skins were so delicate as to enable us to receive small vibrations of the air, we should feel sounds as well as hear them. Our senses were given to us to enable us the more readily to receive impressions from the outside world, and so to be in full responsive relationship to our surroundings—in other words, to lower our threshold for receptive stimuli. Some lower animal forms are provided with a thick cuticle or shell so as not to be too sensitive to outward stimuli; but man is provided in his structure and formation with many receptors, *i.e.* he has many windows into his mind, and as it is impossible for him to add to his windows, it behoves him to keep them clean and bright, for he often sees but does not observe, and he often hears, but does not understand. You may remember Wordsworth's "Peter Bell":

"A primrose by the river's brim
A yellow primrose was to him—and nothing more!

Think of the inner meaning of the anatomical landmarks on the body as seen by the student in comparison with the interpretation of the surgeon, or the meaning of the skiagram to the man in the street as compared with that of the skilled interpreter, or the cleanliness of a room as viewed by the trained nurse in contrast to the idea of the housemaid. Think of the meaning of a landscape to the artist as compared with that to Hodge, who may even gaze at it daily. The critic who told Turner that he never saw a sky with colours like that received an apt rejoinder when told "Don't you wish you could." The botanist enjoys a totally different appreciation of the trees in winter as compared to the woodman; and an astronomer's idea of a midnight walk is vastly different from that of the home-coming reveller. Man misses much because his windows are not clean,

yet we have seen a great improvement of recent years in the window-cleaning industry of the mind, for man can now by means of the periscope see round the corner.

A sensation from a sense is the simplest and most elementary part of the mind, indeed a sensation is an unanalysable constituent of the mind, for it cannot by the most persistent self-examination—described technically as introspection—be split up into anything simpler. A sense corresponds, in the physical world, to the atom; and so the content of the mind is thus made up of many elementary sensations, but no sooner is an elementary sensation experienced by the mind of a child—say the colour red or a simple sound—than it is immediately linked up with some other sense associated with it, so red becomes an orange because it gets associated with colour, shape and smell, and sound becomes the musical box or baby's rattle. A pure sensation is a very fleeting affair and can only be experienced during the earliest phases of infantile life; for this reason it has been called a "psychological myth." It is this immediate tendency for sensations to associate together that is responsible for the growth of the mind, and this linking up works according to two laws, called the law of similarity—for like ideas tend to run together and to recall each other—and the law of contiguity, when ideas which have occurred together also tend to reappear together in the mind. Reference will be made to these laws later on.

When several sensations fuse together, such as the colour of baby's rattle together with the sound it makes, and also its size and shape, then these simple sensations have coalesced to form a *percept*; so the percept is two things. It is the object before me and my mind's view of it—that is, it is the object and the mind reacting to it; but when the objects I have seen—the rattle, or a musical box or an orange—are removed from my presence, I can nevertheless recall or remember them. I can revive a picture or an image of them in my mind—which is a *concept*, or an idea. For instance, I can think of and remember many kinds of oranges—tangerine, Jaffa, Spanish, Californian, and so on—so that groups of percepts form concepts or ideas, and I can further group ideas or concepts of things into greater masses and groups. The formation of concepts or ideas is the beginning of mental development, and is a mark of culture. The more abstract a concept becomes, naturally the more shadowy and dim are the remembered ideas, and for this reason only the few educated and cultured people can indulge in abstract thought; such, for instance, is implied in the discovery and enunciation of the principle of relativity, the law of gravity or the conservation of energy.

Sometimes percepts are false, and then they become hallucinations and the basis of delusions. I hear the

wind through the key-hole and imagine the percept to be the voice of God. Sometimes, also, concepts are false, or a group of concepts or ideas may become dissociated from their normal relationship, then giving rise to delusions, as we see in conditions of insanity described as paranoia, when a patient may imagine he is the ruler of the universe or the King of Kings, or inventor of the wireless, and demands recognition accordingly.

Sensations from the senses are often very strong in youth, and may become dominating, tyrannical and insistent. The boy must have his sweets and the girl her chocolates. In later life the senses lose their edge. The club *habitué* complains that the *chef* has lost his cunning, that his dishes are not so savoury as they formerly were, whereas the fact is that his sense of smell and taste have become blunted by age.

The external senses often enter into competition with internal ideas, as on occasions when we are deeply engrossed in thought. Then when someone speaks to us we may not hear—or we hear but do not attend or perceive—as is recorded of the philosopher whose wife was about to present him with an addition to his happiness. The nurse announced, "It's a boy, sir," to which he coolly replied, "Ask him what he wants; I'm busy."

It is quite possible that religious devotees and martyrs who have suffered for their faith have not fully realized the anguish and pain of their martyrdom owing to the conflict between internal and external sensations.

The human mind, at birth, is without content, yet it is the most wonderful of all natural phenomena. It only begins to grow when charged with impressions from the senses and the ideas they represent. Eliminate all the acquired contents of the mind, as we know to occur in disease, and the mind goes out. Deprive it of all sense knowledge and the mind is a blank. We have seen some rich men at sixty, previously accustomed to hard work, and retiring from a successful business, with the result that the loss of all the accustomed environmental stimuli to the brain has brought on a nervous breakdown and they have become demented. Thus it is that sensations from the senses are the ultimate units out of which the mental content, viz. feeling, intellect and will (and character) are built up. These are the three constituents of the mind, and the first lesson we learn is that it is most necessary to feed the mind by cultivating the senses; we must be accurate and precise in forming our percepts, in making our concepts wider and ever larger and more comprehensive, *i. e.* add to our stock of knowledge, and this quietly, dispassionately, and with full self-confidence, but it takes trouble, and, as Carlyle said, "Genius is the capacity for taking

trouble." We could never swim without many efforts, and so with the mind, continue to exercise it; it will serve you well if you take trouble with it.

Our next step is to appreciate the fact that sensations are always attended either with a feeling of pleasure or the reverse. When sensations are pleasant we wish to continue them, and naturally the reverse if they are not. The fact that feeling is always associated with sensation is an important factor in conduct, for we are always guided by the feeling, *i. e.* the attitude of pleasure or pain. Feeling, in psychology, is always used in the singular; it has nothing to do with the popular application of feelings. Feeling is the state of mind produced in us by an object (a percept, concept or idea), and feeling is ultimate and unanalysable. It naturally takes two forms, *viz.* those mentioned as pleasure or pain. Every human being attempts to pursue pleasure or happiness, *i. e.* to accumulate things agreeable and ward off their opposite.

It is a fundamental maxim in psychology that all pleasurable states favour and go with an increase in the vital functions, *i. e.* pleasurable states are an aid to health, and we should therefore try to cultivate them—cultivate cheerfulness, happiness and gladness, and avoid gloom, depression and dullness. Don't be morose. Fear is the most paralyzing of all the emotions, and is the cause of nearly all the neuroses. Avoid anger and fear. The educated and the cultured give way to neither. "Fearless minds climb soonest into crowns" ("Henry VI," Part III). William James said "An idea is half an act," and if you assume an attitude you are halfway to reaching it. If I think of catching the train I begin to run to the station. If I think of the wards, I am on the way there. If I think of a hard task I already begin to tackle it. The way to be courageous is to assume the attitude of courage. Hold your head up and high, keep your shoulders square and press your neck against the back of your collar. Be convinced of your strength and then count your blessings. If you do so, the balance of the account will be well in your favour and you are bound to succeed.

We have now reached the second division of the mind, *viz.* the reason or the intellect, a stage also described as *cognition* or *awareness*, described by Halliburton as "the electric force of the brain." We receive sensations, which mean not only the stimulation of ideas, but the response of the mind to them. In the exercise of the reason we discriminate, we form judgments, we pass from one judgment to another, either deductively, as when I say, "All medical schools have industrious students and capable nurses"; "St. Bart.'s is a medical school," therefore "St. Bart.'s possesses these treasures";

or inductively, which is reasoning from the particular to the general, or inferring from the known to the unknown, as if I were to say, "A well-equipped hospital has a psychological department"; "All the London hospitals are well equipped," therefore "All the London hospitals have a psychological department," which, of course, may not be true, though logically correct. It is the work of the reason to compare, to judge and to criticize. Therefore you should sit every night for half an hour to think over the events of the day, *i. e.* introspect, in order to discover the relation, the implication, the association and the interpretation of what you have heard and seen and read during the day. You will find that practice in this will be invaluable to you as a mental exercise or mental gymnastics. It is well known that reason is much influenced by the feeling, which is associated with every idea, *i. e.* whether this be pleasurable or painful; in other words by their "affective tone," and this so-called "affect" is a great help to remember, to recall and to revive our thoughts; indeed, remembrance is necessary in order that concepts or ideas may coalesce into larger and larger association masses and knowledge.

Memory, which is an element of reason, is the best friend of the student. "It is the treasure-house of the mind" (Thomas Fuller). It is well to trust the memory and to strengthen it by recalling the past events of each day. After learning a thing, physiology teaches us to rest for a while, so that Nature's repairs—which bring new material—may make the impression left upon the neurons more secure, for the process of learning does not cease with the actual impressions imparted; it goes on for a time and so adds to our efforts. As Bain said, the memory depends on three things: (1) The plasticity, as it were, of each individual; (2) a certain amount of repetition, as the pathway is deepened each time; and above all, (3) concentration of the attention. Sometimes reading aloud helps the memory, for it adds sound to sight, as also the remembrance of the action of the vocal muscles—what is described as the kinæsthetic memory, the muscular element of thought—a very important factor. It is well known that many past experiences of our lives are forgotten. They drop out of the conscious mind, and remain in what is described as the subconscious mind, yet they can be recalled by an effort of the will. We can recall last year's View Day or the Christmas theatricals, or a long-past Speech Day at our school—all from our subconscious mind. Ideas when remembered are said to be in consciousness—a new and very difficult word for us, but only meaning the state of the mind at one moment, for consciousness may be described as the sum total of the mental processes now or at any particular time; in other words, my

consciousness means the ideas that are in my mind at the present moment.

If we look on the mind as a running stream, and if we could make a cross-section of this stream and then look into the divided parts, we should discover or be aware of (cognition) many sensations, also of pleasure or the reverse (feeling), and lastly, a tendency to act or to move in response to them—a state called conation, or the will to act—thus yielding the three constituents of the mind—feeling, intellect and will—yet made up of many impressions; as stated these would be abstractions, emotions and sensations, doubts and determinations, and which together would constitute our consciousness.

There is, however, another term “with the definite article and a capital T”—“The” unconscious, a word dearly loved by the admirers of Freud, who, by the by, is greatly revered by a distinguished teacher of this School, who, if I rightly infer, does not seem to know that Freud was anticipated over half a century ago by Dr. W. B. Carpenter in his description of “unconscious cerebration.” Some have doubted the existence of the unconscious mind, asking how can we have consciousness of that which is itself unconscious? From our experience and from facts, I think, we are justified in accepting the existence of an “unconscious” division of the mind, and indeed in recognizing it to be a very extensive, active and dynamic area of the mind.

This part consists of buried memories, which it is claimed only the technique of psycho-analysis can restore. It also contains inherited tendencies. We know that our parents under certain circumstances acted in certain ways, and we are told we ourselves act exactly in the same way under similar conditions, yet without knowing it, for we have, unconsciously, inherited the tendencies so to act. An instance is, we go to bed with the determination to get up, say, at 4 a.m., and on the stroke of the hour of four we wake. The anxious mother sleeping with her sick child hears no noise from the traffic outside, but the moment her baby moves she hears it and wakes, though deaf to other sounds, which go to support the view that there is a dynamic trend in the unconscious mind, which makes the conscious part act. Also, it is claimed that the beat of the heart, the processes of digestion and the respiratory activities, now in the unconscious mind, were formerly conscious acts.

Consciousness and unconsciousness have been likened to the two parts of an iceberg, the visible and exposed part being the former, whilst the submerged part and nine-tenths of the whole is the unconscious.

Consciousness has also been likened to that part of the surface of the ocean which reflects the shimmering

gleams of the setting sun, active and in perpetual motion, whilst the rest of the vast surface of the sea represents the unconscious mind—also in perpetual motion.

Again, the mind has been compared to two circles, an inner small one with a central focus (and an indistinct margin) representing consciousness, the fringed margin being the subconscious and the great outer circle the unconscious division.

Lastly, probably the most appropriate picture of all represents consciousness as a dome resting on a large square structure which is the unconscious mind, but separated from the conscious part by a permeable territory or diaphragm—the subconscious mind.

ROBERT ARMSTRONG JONES.

(To be concluded.)

AN INDICATION FOR VENTRICULOGRAPHY.



THE first step in the diagnosis of a tumour of the brain is the realization that the clinical picture, composed of the history and the demonstrable evidences of interference with cerebral function, is compatible with a gradually progressive lesion associated with increasing intracranial tension. The next is the localization of the lesion.

Careful and repeated examination of the patient by a practised observer will localize a very large proportion of brain tumours by clinical methods alone. How large this proportion may be is a subject of argument even amongst those best qualified to judge. An account of his own experience was recently published by Sir James Purves-Stewart, who does not hesitate to recount his errors in diagnosis, many of which are justly labelled unavoidable. Sir James maintains that in many cases the diagnosis must remain uncertain, and goes so far as to say that an uncertain diagnosis is sometimes a sign of wisdom.

When considering the surgery of intracranial tumours it must be recognized that accurate localization is of the first importance. Diagnosis in some other regions involves one's reputation, or at most sixpence; in brain surgery it is too often a matter of life and death, and the wisdom of making an uncertain diagnosis is overwhelmed by the folly of acting upon it.

It is therefore our duty in cases of uncertainty to use every available aid to clinical examination, and one of these is ventriculography. It is to be clearly understood that ventriculography does not, and cannot, replace clinical observation, and that it is useful and



FIG. 1.

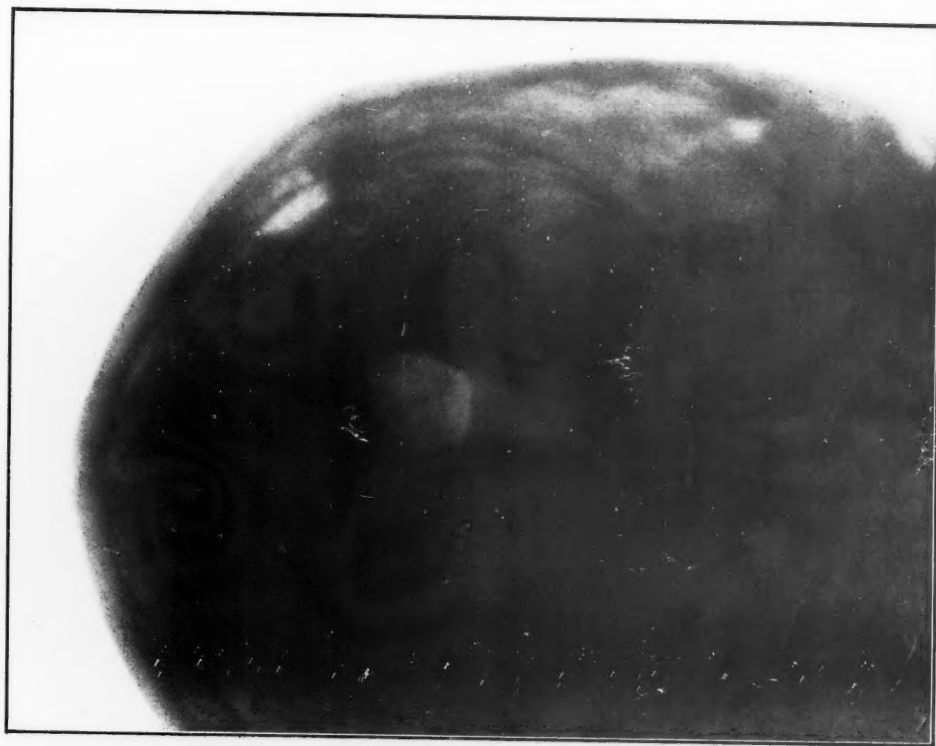


FIG. 2.

Adlard & Son, Limited.

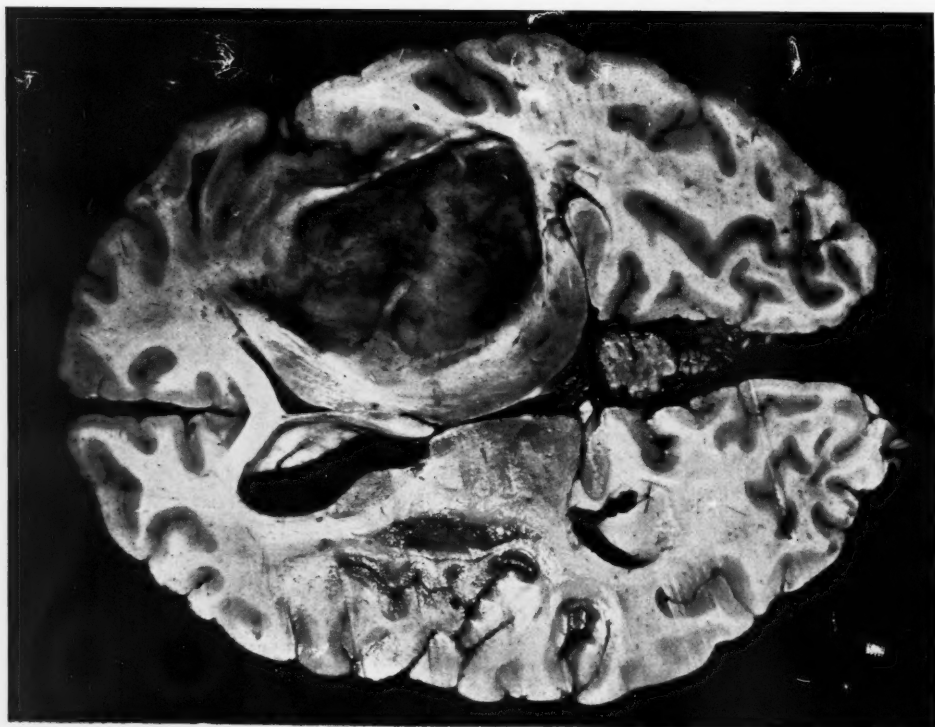


FIG. 3.

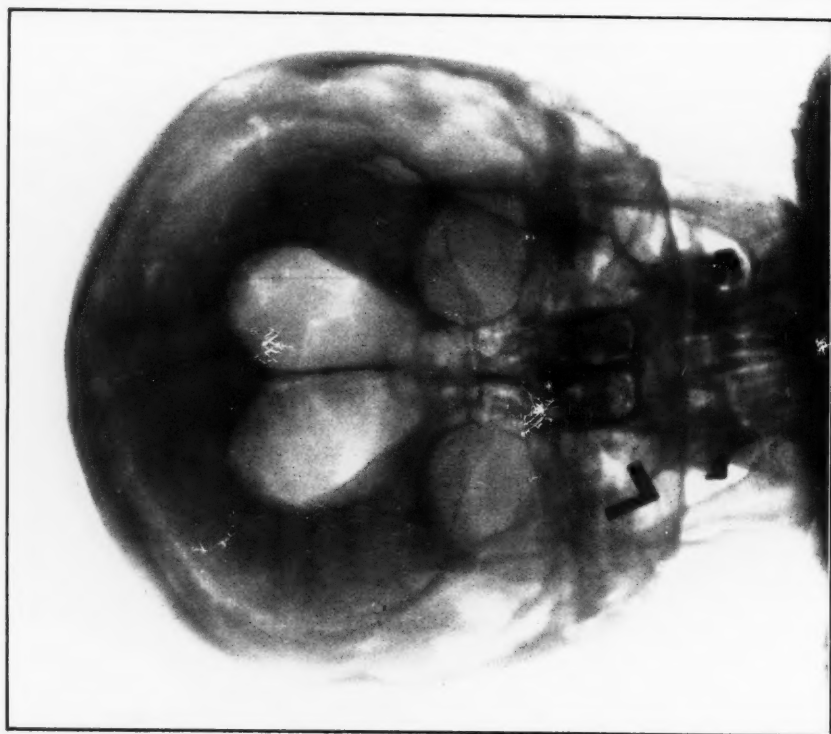


FIG. 4.

necessary in a comparatively small proportion of all cases of cerebral tumour. But if in a given case there is conflicting clinical evidence which might lead to a serious diagnostic error, and if in the circumstances it is likely that ventriculography will help to differentiate the true from the false localizing signs, then its use is justifiable. It would be wrong to employ the method in every case, not only because in many it would be redundant, but also because it cannot be carried out entirely without risk.

The most serious error is to mistake a tumour above the tentorium, most commonly in the frontal region, for one in the cerebellum. If, acting upon this diagnosis, a suboccipital exploration is carried out, death as a direct result of the operation is inevitable. And although the applications of ventriculography are numerous, these brief notes will be confined to the illustration of its value in avoiding this common pitfall.

Its value lies in that, whereas a tumour situated in the cerebrum is likely to displace or partially obliterate the ventricles, a subtentorial tumour is likely to produce symmetrical distension of the ventricles by blocking the cerebro-spinal fluid pathway.

DESCRIPTION OF CASES.

A woman, *æt.* 29, had suffered from headache at intervals for a year, and in the four months preceding admission the headache had been more severe and constant, and she had complained of failing vision, of vomiting, especially in the morning, and of pain at the back of the neck passing down to the left shoulder. After admission vomiting became the most prominent symptom. She was found to have intense bilateral papilloedema, slight atonia and ataxia of the left arm, and suboccipital tenderness. Speech, memory and attention were perfect, behaviour normal, and no weakness or sensory loss was detected.

Suboccipital exploration did not reveal the suspected cerebellar tumour, and she died a few days later. Section of the brain showed a very large left frontal tumour (Fig. 1), which obliterated the anterior horns of the lateral ventricles. Had ventriculography been employed—and it might well have been, considering that, apart from the suspicious history, the slight atonia and ataxia of the arm was the only positive evidence of a cerebellar lesion—this error would have been avoided.

A man, *æt.* 39, was admitted suffering from intense headache, and vomiting which simulated intestinal obstruction. For a month before admission he had had giddy attacks, and weakness and pain in the left shoulder. There was no papilloedema. He was deaf in the left

ear, and there had been a chronic discharge from that side. Nystagmus, coarse to the right, fine to the left, and weakness of the left side of the face led to the diagnosis of a left cerebellar or extracerebellar lesion. Repeated examination, however, brought to light certain points in favour of a frontal lesion—the earliest symptoms of all had been alterations in behaviour and demeanour, with impairment of memory; and slight and variable inequality in the reflexes cast suspicion on the pyramidal fibres to the left side of his body.

Ventriculography was decided upon, and the left lateral ventricle was punctured and the cerebro-spinal fluid replaced by air. It was found that although the head was rotated in every direction, no air could be made to pass into the right side (Fig. 2), indicating a block, presumably by tumour, of the right foramen of Munro. Exploration and decompression of the right cerebral hemisphere was carried out, but the tumour did not reach the cortex. The patient did well for a time, but a few weeks later he died after a series of fits. The section of the brain (Fig. 3) shows that hæmorrhage had taken place into the tumour, which can be seen to occlude the right foramen of Munro.

The third case to be quoted is that of a woman, *æt.* 51, who had previously suffered from uterine hæmorrhage, and whose symptoms were attributed at first to anæmia resulting therefrom. She had had headaches for years, which had recently become more severe, and twelve months before admission she had attacks of giddiness which caused her to totter as she walked. For six months these attacks had caused unsteadiness even when sitting, and for three months she had been unable to stand. Shortly before she came in she had noticed flashes of light before her eyes, and sometimes believed she saw three objects instead of one. Papilloedema developed while she was under observation, was never severe, and was more marked on the right side. There was weakness of the left side of the tongue and some hypotonia of the left arm, but no nystagmus or unilateral ataxia.

The case presented so many puzzling features that ventriculography was decided upon, and a high degree of symmetrical internal hydrocephalus was discovered (Fig. 4), indicating a block in the cerebro-spinal fluid circulation below the tentorium. Suboccipital exploration revealed a papilloma of the choroid plexus of the fourth ventricle projecting by the side of the left cerebellar tonsil, and a radon seed was inserted into it. The operation was performed nine months ago. For the past six months she has been able to walk without a stick, and carries out her household duties without difficulty.

It may be suggested that in cases of uncertainty it would be safer and wiser to carry out a subtemporal decompression, and be content to let the tumour remain unlocalized. It is well known that many patients in whom a cerebral tumour has been diagnosed on the best of evidence have been permanently relieved, and even apparently cured by this operation. This happy accident cannot be anticipated, however, if the tumour lies beneath the tentorium, and there are two good reasons for not performing subtemporal decompression for a subtentorial growth.

The first is that in these cases the increase in intracranial tension is due almost entirely to internal hydrocephalus, and the formation of an opening in the skull and dura merely allows for the accommodation of an increased volume of cerebro-spinal fluid. The hernia in the decompression area comes to contain in its centre a lateral projection from the cerebral ventricle, and the operation is therefore valueless.

The second and more important reason is that tampering with the intracranial contents above makes a subsequent operation below the tentorium more hazardous.

(Note.—The lateral radiograms have not been inserted as they are of no particular interest in the cases quoted.)

J. P. Ross.

(From the Surgical Professorial Unit.)

DUODENAL ULCERATION: AN HISTORICAL SURVEY, WITH A RECORD OF AN UNUSUAL CASE.

IT was not until the beginning of the nineteenth century, the period of consolidation as Singer¹ calls it, that duodenal ulceration was recognized as a pathological entity. Matthew Baillie² in 1799 published his *Atlas*, and among the illustrations is a typical duodenal ulcer. He describes it as "a considerable ulcer in the duodenum, which has destroyed a part of all the duodenal coats." The specimen was in his collection.

Clinically it was not recognized till some forty years later; up till then duodenal dyspepsia was in reality cholecystitis, and true duodenal dyspepsia was regarded as a form of gastritis or hypochondriasis and treated with bitters or chalk.

Broussais,³ the exponent of heroic blood-letting, considered gastro-enteritis the "basis of all pathology," and in 1823 he published a thesis on chronic duodenitis;

the cases, however, are inadequately described. In 1824 Dr. Irvine,⁴ of Philadelphia, described a case presenting the classical signs of pain some four hours after meals, relieved by vomiting or more food; the attacks gradually increased in frequency and at post-mortem an ulcer was found in the duodenum. John Abercrombie⁵ in his work on the stomach admits that little is known of the diseases of the duodenum, and merely quotes cases from Broussais and Irvine. Curling⁶ in 1841 described a number of cases of duodenal ulceration occurring after severe burns, although in the light of modern investigation this has been found to be relatively rare.

The true interpretation of the condition was necessarily delayed until the functions of the organs could be more closely investigated by means of the test-meal and radiological procedure. Carl Anton Ewald,⁷ in 1875, first employed intubation for exploring the contents of the stomach; and with his pupil, Ismar Boas, devised his test breakfast of tea and toast in 1885. This was amplified by Rehfuess,⁸ whose fractional test-meal is used, with slight modification, to-day; showing, as it does, not only how much acid is secreted, but also giving an accurate measure of the motor efficiency of the stomach.

The surgical treatment originates in 1881, when Woelfer,⁹ at the suggestion of his friend Nikoloidoni, performed anterior gastro-enterostomy on a case of gastric carcinoma with pyloric obstruction. Unfortunately the patient died from obstruction in the transverse colon; this led Courvoisier¹⁰ to suggest the posterior route. In 1885 Von Haeker¹¹ performed the first posterior gastro-enterostomy which with minor modifications is essentially the operation performed to-day. It was not until 1893 that surgery was applied to duodenal ulceration, when Doyen¹² suggested that the pain was mainly due to spasm, and from that date gastro-enterostomy has been the most popular operation.

The frequency of the condition and its full importance appear to have received fuller recognition during the period 1900-1915, when Moynihan¹³ and Mayo¹⁴ from the surgical aspect and Hurst¹⁵ and Maclean¹⁶ from a medical standpoint evolved the modern interpretation and treatment.

The medical treatment is essentially dietetic. The older method devised by Leube¹⁷ consisted in giving as much rest to the stomach as was consequent on withholding all food and by attempting to supply nutriment by means of rectal feeding, with a gradual return to a modified diet *per os*. This method has many objections. In 1904 Lenhart¹⁸ introduced his scaled diet, consisting of many small feeds rich in protein. This diet has been modified for American palates by Lambert,¹⁹ and at St. Bartholomew's Hospital by Langdon Brown²⁰

in the substitution of plasmon for meat, the reduction of eggs in the second week and the addition of pounded fish. This form of treatment yields good results, and does not produce the intense hunger of the Leube method. It has an objection in that the excess of protein may increase the gastric secretion. The intensive alkaline treatment was introduced by Sippy,²¹ of Chicago, in 1915. The rationale is to protect the ulcer from the secreted hydrochloric acid, and is achieved by exhibiting belladonna before the feeds and giving large doses of alkalis after meals. The basis of the diet is milk and cream. The Sippy treatment has been warmly advocated in England by Hurst,²² and has been used with considerable success by Maclean²³ and others. However, in a certain number of cases (particularly when chronic nephritis is present) a state of alkalosis has been set up, but the condition is rare, and should symptoms arise the treatment may be stopped for a few days.

There are three schools of thought as to the operative treatment of duodenal ulcer :

(i) Those who consider that all duodenal ulcers can be cured by "appropriate" medical treatment, and that no surgical interference is warranted.

(ii) The other extremist school, which believes that some form of operative procedure is imperative and medical treatment is merely palliative.

(iii) The rational school, to which the majority of the profession belong, which holds that all cases (saving those in which there is *undoubted* organic pyloric or duodenal obstruction as demonstrated by radiography), should be given an efficient course of medical treatment, and if this fails to cure an operation should be performed. There is unanimity on the point that any septic foci such as teeth, tonsils, sinuses or appendix must be removed, but the exact type of local treatment is a vexed question, and it will be necessary to outline the various methods. The majority of surgeons follow Moynihan in the performance of gastro-enterostomy, together with destruction of the ulcer by the actual cautery or deprivation of its blood-supply and temporary closure of the pylorus by an encircling suture. The drawback to this operation is the occurrence of a gastro-jejunal ulcer. Lewishon²⁴ found that an ulcer developed in 34% of cases, though the majority of competent observers record an incidence of about one-tenth of this figure. These results, together with the view that the ulcers are due to an underlying diathesis, have led to the adoption by certain surgeons of operations calculated to reduce the underlying hyperacidity. Haberer²⁵ is the leader of the school which advocates the routine performance of partial gastrectomy for duodenal ulcers. But the operation is dangerous even in the hands of its warmest advocates (a mortality of 5

to 10%). It is necessary to remove a very large portion of the viscus to produce any marked diminution in gastric secretion, and this will produce a very profound change in the economic after-life of the patient, together with the possibility of Addisonian anæmia.²⁷ Furthermore there are a large number of cases on record of secondary ulcers after partial gastrectomy. Pannett²⁶ in a recent paper advocates partial duodenectomy, which he has performed in 61 cases. The operation is difficult and sometimes impossible. As yet it is too early to discuss results, but it appears to have no great advantages over gastro-enterostomy.

The modern concept of the causation of duodenal ulceration as expounded by Hurst²⁷ and his followers is that it is the resultant of a number of isolated factors. The underlying factor is a duodenal diathesis, which reveals itself in a congenital (and sometimes familial) hypertonicity of the stomach, with vigorous peristalsis and rapid evacuation, associated with hyperchlorhydria and digestive hypersecretion. This condition is much commoner in men than women and is compatible with perfect health. It is probably due to an unusual degree of localized tonic activity of the vagus, as no other signs of vagotonia are usually present. The essential exciting cause, as shown by Rosenow²⁸ is a minute localized necrosis in the mucous membrane produced by a specific strain of streptococcus. In most people these areas would heal, whereas in the presence of the duodenal diathesis, the area will be digested by the acid gastric juice, with which it is in contact for several hours during the day and intermittently during the greater part of the night.

Therefore not only will healing fail to occur but a chronic ulcer may develop. Further, it has been shown that specific streptococci, isolated from infected teeth or tonsils, have no effect when injected by mouth, even in large quantities, thus making it apparent that the infection is hæmatogenous. The secondary exciting causes are numerous. Peripatetic occupations resulting in meals at irregular times which are eaten too rapidly without chewing the food and indulgence in food containing mechanical and chemical irritants are of first importance. Alcohol taken between meals is diluted by the residual stomach contents in normal persons, whereas in those with actively functioning stomachs the alcohol will reach the duodenum in an almost undiluted form. More particularly will this be the case should it be taken as an *apéritif* before a major meal. Excessive smoking exaggerates the hyperchlorhydria and hypertonus already present. Many French authors hold that practically all ulcers are syphilitic, but in this country, at any rate, this statement cannot be accepted. The onset of symptoms has been

shown by Fenwick,²⁹ C. F. Martin³⁰ and others to be commonest in the third decade of life, the percentage gradually decreasing as age advances.

The case to be described is of interest, both from the unusual age of the patient, and the rapid effect of the operation on all his symptoms:

Arthur C—, æt. 16, a shop assistant, was admitted to St. Bartholomew's Hospital on March 22nd, 1928, complaining of pains in the abdomen and back. His history was as follows: He was in his usual health until three years before, when he commenced to have attacks of abdominal pain in the region of the umbilicus. The pain came on one hour after meals and was relieved by vomiting or by

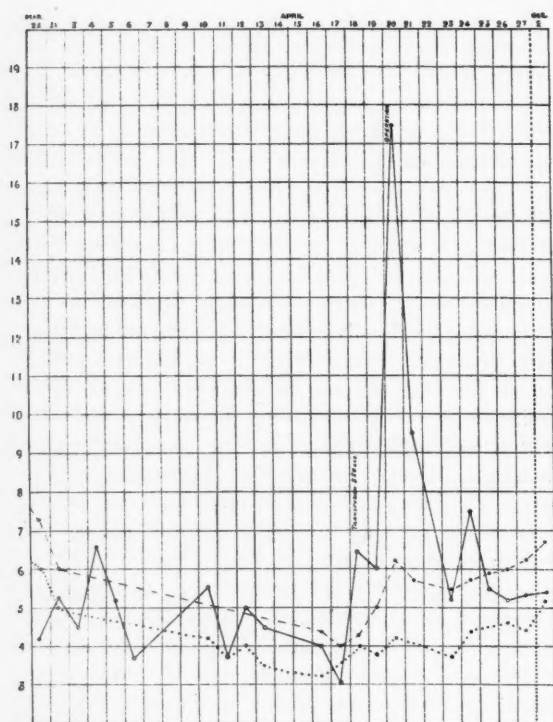


CHART OF DAILY BLOOD EXAMINATIONS.

..... = R.B.C. $\times 10^6$.
 ————— = W.B.C. $\times 10^3$.
 - - - - - = Hb. % $\times 10^{-1}$.

taking food. An attack would last for about a week and then he would be free from pain for a period of about three months. However, the intervals of freedom became shorter, and by December, 1927, the pain had spread to the left lumbar region, was continuous and unrelieved by food. There had been some difficulty in commencing micturition, and for the last six months one nocturnal frequency. The patient has always been constipated and had noticed that the stools were dark in colour. He had not been losing weight. There was nothing in the family or past history relating to his present condition. He is a moderate smoker and takes no alcohol. On admission he looked well, but in pain. Temperature 98.6° F. The tongue was clean. The teeth were in good condition, the tonsils healthy, and no glands palpable in the neck. The heart and lungs were normal. The abdomen was retracted, but the movement was

good and no tumour could be seen. There was resistance to palpation over the whole of the right side of the abdomen, more particularly in the lower quadrant. There was no marked tenderness. The liver was not enlarged and the spleen and kidneys were not felt. Nothing was discovered on rectal examination. The urine was normal. The blood-count revealed some degree of secondary anaemia (*vide* chart), and occult blood was found in the stools on three occasions. The Widal reaction was negative to typhoid and paratyphoid A and B. He was more comfortable on being put to bed, but by the beginning of April the pain had returned with renewed vigour and heroin injections were necessary to relieve the pain. His diet corresponded to a seventh-day Lenhartz diet, and alkalies were being exhibited with but little relief. On April 14th he was investigated by means of a barium meal. This revealed a high, slightly oblique stomach, exhibiting brisk peristalsis, with marked delay in emptying. The duodenal caput was small and irregular. There was delay at the duodeno-jejunal junction, with some reverse peristalsis. When it passed this region the stream was narrowed. The diagnosis was that there was some abnormal spasm of the pyloric sphincter, associated with cicatrization of the duodenum and considerable barium residue, which might be in an ulcer cavity. On the same day acetone bodies were found in the urine. The melena was persisting and the patient becoming steadily more anæmic. On April 19th transfusion of 550 c.c. of blood was performed to improve his condition before operation. On April 20th the patient was operated on by Mr. J. P. Ross under a general anæsthetic. The abdomen was opened through a right paramedian incision. On opening the abdomen the anterior and posterior aspects of the duodenum were found to be greatly scarred, with adhesions to the pancreas and gall-bladder. The appendix was next examined and found to be abnormally long and thickened. The stomach was normal. Posterior gastro-enterostomy was then performed. The pylorus was partially occluded by sutures passing through the anterior wall and two arteries which appeared to supply the ulcer were underrun. The appendix was then removed and the abdomen closed. On the day of the operation the patient was only allowed a half-ounce of water hourly; this was increased on the following day to two ounces two-hourly, and on April 23rd a Lenhartz diet commenced. The melena ceased immediately after the operation, and there was no further pain save a slight throbbing in the wound. He made an uneventful recovery and was discharged on May 8th, when he weighed 7 st. 7 lb.

After-history.—He was seen six months later when he was in perfect health and had gained a stone and a half in weight. There had been no return of the pain and he was living on a slightly modified diet. The abdominal scar was healthy and showed no sign of herniation.

The interesting features of the case are: (1) The early age (13 years), at which symptoms commenced. The incidence of cases below the age of twenty (apart from cases of ulcer neonatorum) in less than 1% in most statistics. O'Flynn³¹ reported the perforation of a duodenal ulcer with a six years' history in a boy of 14 years. The patient was operated on and recovered. Girling Ball³² recorded a case of a man, aged 17, whose ulcer perforated, in whom there was a history of symptoms from the age of 13. (2) The presence of acetone bodies in the urine, revealing the fact that some degree of ketosis was present. This may have been due to inanition. (3) The daily blood-count reveals the gradual increasing anaemia due to the profuse melena, and the immediate improvement after the transfusion and operation with no recurrence of symptoms.

While in St. Bartholomew's Hospital the patient was under the care of the Surgical Professorial Unit, to whom I wish to express my thanks for permission to publish

the case-notes, and particularly to Mr. J. P. Ross for his assistance and advice.

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A. H. T. ROBB-SMITH.

THE BUSY BEES OF ST. BARTHOLOMEW'S HOSPITAL.

THE first Annual Swarming of the "Busy Bees" took place on Saturday, January 19th, in the Great Hall, which was kindly lent for the occasion by the Treasurer and Governors of the Hospital. There were about 300 guests present, of whom a large number were children and young people—the Bees being the Junior Branch of the Women's Guild. The gaiety of the scene was added to by the balloons and paper hats given to each child on arrival.

Lady Sandhurst received the Hive collecting boxes; the 85 which were brought in at the party contained a total of £54 6s.

Parties were taken to see the cots in President and Lawrence Wards, which are supported by the Bees.

Tea was then served, after which Lady Sandhurst spoke to the assembled Bees about the work they had achieved during the past eight months, since their inauguration at the Mansion House last May, and congratulated them on their continually increasing membership, which is now well over 700. Mr. Rawling followed with a story about a wonderful Bee and then told the children of the plans for the future.

Then came the entertainment, which was given by the St. Bartholomew's Hospital Dramatic Society. It consisted of three parts: "The Cannibals," a conjuring entertainment, and a pantomime—the last being specially written for the occasion. The whole programme was greatly enjoyed by the audience, who gave the performers enthusiastic applause. The Orchestra of the Dramatic Society played throughout the afternoon, and contributed largely to the success of the party.

ARMS AND THE MAN.

IN 1885, common sense in Bulgaria seems to have been as disconcerting as a wasp in a policeman's pants, but, as usual, some people could develop an immunity against the sting. The play, "Arms and the Man," performed in the Great Hall this January by the Bart.'s Dramatic Society was George Bernard Shaw's first attempt, hastily completed in 1894, at a pleasant play. It was selected, I believe, as it was thought to be most suitable for a revival of an old custom of the Society to cast men for the women's parts, owing to its Shavian avoidance of real love; and in this connection we read that "he denounces love because his asceticism revolts from the sensuality that is the desecration of love"; if we extend this theory to the other necessities of life, clothes and food—but enough.

The plot is based on the reactions of a romantic couple toward common sense, and in some magnificent character drawing we see again how much more adaptable is the fairer sex. (I am not certain whether Shaw would not call this a euphemism.) The background is an incredible Bulgaria; incredible to-day, but in 1896, two years after the play was written, when an eminent Bulgarian lady took exception to one Stambooloff's neglect of his nails, he was shortly after assassinated, and his fingers cut off and given to his wife, who hung them in a large bottle of methylated spirits, placed in the window of her dining-room, so that passers-by could see

the fingers floating dimly in the jar like little pickled cucumbers. Petkoffs beware!

This year the Dramatic Society has lost three old friends in John Hunter, Holdsworth and George Roxburgh, and it was with much interest that we watched the newcomers. Mr. Clive Barnes is to be congratulated on the careful way in which he produced the play. The action was easy and rarely dragged. Especially noticeable was the very excellent stage grouping. With more attention to individual characterization and less devotion to the book, there should be few plays beyond

as Louka gave a performance as good as it was unobtrusive, and his movements were exquisitely feminine. Catherine Petkoff (Mr. Robert Cross) is a thankless part which was surely handled and developed, so that on reading the play after the performance one was surprised by the little she really had to say.

Mr. Colin MacVicker as Bluntschli seemed to enjoy the part, and, twisting the author's intention to suit his appearance, converted middle-aged reason into youthful enthusiasms, which in the last act for one graceful moment achieved a very remarkable perfection—an



IN MAJOR PETKOFF'S LIBRARY. ACT III.

his reach. We were glad to see that he had cast men for the women's parts, as this makes the play more of a family affair, which is good for the Society, and more fun for the audience. Having shown what they can do this year, however, they would be unwise to make a permanent policy of what must, of necessity, limit the range of possible plays.

Mr. William de Wyt as Raina succeeded in putting life into a part, without which the play would have failed; and it was good to see the use he made of silence, by keeping still (few amateurs can stand still on the stage and say nothing). He would have done well, however, to speak more naturally. Mr. Keith Vartan

unauthorized but successful version. Who could doubt the passions, however, or rather their existence, in the gallant Major Serjius Saranoff, Mr. Derrick Coltart? And yet, as the part was played, Mr. Shaw's befuddled patriot got much of our sympathy, and if Mr. Coltart appeared at times a little uneasy, this was not out of keeping. Mr. William Nicholson (Nicola) spoke with such charm that the part suffered, for some harshness is in keeping with the pride of a good servant. Mr. Barbour, as the Russian officer, gave us no chance to criticize him, and neither did Mr. Ashley Miles as Major Paul Petkoff. This performance was in the best Bart.'s tradition, and was played with that ease which is the backbone of a

comic part, although his monotones perhaps did not suggest the primitive heroism of a Petkoff.

An outstanding feature of this show was, however, the lighting which, using front and side floods, achieved effects which far exceeded those often seen on the legitimate stage, and Mr. Orr, the stage-manager is to be congratulated on obtaining excellent results with a minimum of scenery. He was also connected with what, is, in its way, an outstanding event, and that is the very notable revival of the Bart.'s Musical Society, which did much to charm the ear and cover the noise of many enthusiastic scene-shifters, to whom our thanks are due.

This year the A.D.C. have attempted something of unusual difficulty in a light comedy, and deserve our warmest congratulations on their success, much of which is due to the producer, under whose care we hope to see even greater things. We would like to suggest that they have now reached the stage when they should not confine their attentions to one play in the year, but should aim at being a much more important factor in the social life of the Hospital.

E. D. M.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

After starting the season indifferently the 1st XV has settled down well, and should make a good fight to retain the Hospital Cup. We meet University College Hospital on February 5th, and if we are successful we shall play the London Hospital, whom we beat in the final last season.

We have been unfortunate in having had three matches scratched in five weeks owing to snow, with the result that the team is not as fit as it should be, as was shown when we lost to the Harlequins in the last four minutes, and when, after leading by eight points at one time, we were hard pressed by the Old Blues in the concluding quarter of an hour.

Under the leadership of R. N. Williams, the forwards, although light, have developed into a strong combination, particularly in the loose. The backs have more scoring power than we have had for some seasons, but on occasions it appears that our defence is not so good as that which won us the Cup last season. The halves seem to improve with every game they play, but unfortunately A. H. Grace, who was settling down so well at full-back, had two metacarpals fractured playing against the Old Blues, and he will not be able to turn out in our first cup-tie.

Recent results are as follows:

- Nov. 24. v. Devonport Services, away, lost, 13-19.
- " 26. v. R.N.E.C. (Keyham), away, won, 30-0.
- Dec. 1. v. Plymouth Albion, home, lost, 3-19.
- " 12. v. R.M.A. Woolwich, home, won, 30-0.
- " 15. v. Northampton, away, scratched, snow.
- Jan. 5. v. Harlequins, home, lost, 10-19.
- " 9. v. R.N.E.C. (Keyham), home, won, 25-3.
- " 12. v. Bradford, away, scratched, snow.
- " 19. v. Coventry, away, scratched, snow.

ST. BARTHOLOMEW'S HOSPITAL v. OLD BLUES.

On January 26th the Old Blues were defeated at Winchmore Hill by 1 goal 1 try (8 pts.) to 2 tries (6 pts.). The Hospital were the superior side, especially at scrummage half-back, where J. T. C. Taylor once more showed what an elusive player he is. He was

ably supported by C. B. Prowse, and, indeed, these two players formed the mainspring of the Hospital attack. E. M. Undery made several attempts to break through the home side's three-quarter line, but their defence was sound. The visitors were somewhat handicapped by the slow service from the scrummage, due to the fact that, choosing to play seven forwards against the Hospital eight, they found it difficult to get the ball. However, in the second half they improved in this respect, and during the last few moments of the game the Hospital had to defend desperately to prevent them from scoring. But for nine-tenths of the play the St. Bartholomew's forwards were by far the better, their following up and dribbling at times being excellent. C. R. Jenkins, J. R. Jenkins and V. C. Thompson were particularly noticeable, while W. L. M. O'Connor and T. N. Pearce did a lot of good work for the visitors.

The Hospital pressed from the start, and C. R. Jenkins, intercepting a pass between the opposing half-backs, scored a try, which C. B. Prowse converted. The Old Blues then worked their way to their opponents' line, and R. A. Jones was nearly over in the corner, but the Hospital relieved with some excellent work in the loose. Soon afterwards C. B. Prowse broke through and scored, but he failed to convert his own try. Just before half-time R. A. Jones scored for the Old Blues following some wild passing by the Hospital backs in their own "twenty-five."

The second half was very even until the last few minutes. A. H. Grace injured his hand, and was obliged to leave the field, and soon afterwards S. H. Wales dived over for an unconverted try. The Old Blues' forwards made a tremendous rally, but they were unable to score.

The teams were:

St. Bartholomew's: A. H. Grace (*back*); J. T. Rowe, T. E. Burrows, C. B. Prowse, J. D. Powell (*three-quarters*); F. J. Beilby, J. T. C. Taylor (*halves*); R. N. Williams, C. R. Jenkins, H. D. Robertson, C. H. Bateman, V. C. Thompson, H. G. Edwards, A. Barber, J. R. Jenkins (*forwards*).

Old Blues: W. H. Mills (*back*); R. A. Jones, A. C. Benatt, E. M. Undery, T. G. Jennings (*three-quarters*); S. H. Wales (*seven-eighth*); H. E. R. Wales, N. I. Buchan (*halves*); J. N. Young, N. K. Payne, T. N. Pearce, E. A. Hills, W. L. M. O'Connor, A. P. Hunter, R. E. Peters (*forwards*).

HOCKEY CLUB.

ST. BARTHOLOMEW'S HOSPITAL v. SITTINGBOURNE.

Played on January 12th at Winchmore Hill. We were to have played the Old Uppinghamians, but they scratched at the beginning of the week, and we were lucky to obtain this fixture through the *Hockey World*.

They advertised themselves as a team which had an unbroken record for two seasons, so we took it upon ourselves to shatter it or break our own record of half a season.

They won the toss and defended the bottom end, and in the first ten minutes or so they were all over us and scored two good goals. Then one of our opponents received a cut on the forehead from the ball, and was taken off by McCay for repair. From this point of the game we rallied, and soon drew level with goals from Francis and Symonds. Shortly after, we drew ahead with another goal from Francis, and were leading 3-2 at half-time.

After the interval we again took up the attack and Francis again scored. Our opponents now returned to the attack, and using their speed downhill were only stopped from scoring in the nick of time; one goal, however, was netted. A splendid bout of passing amongst our forwards enabled another goal to be scored by Francis. Towards the end they scored again. Thus we won by 5 goals to 4—one of the best games this season. I think I am right in saying that we had the strongest forward line against us that we had met.

I should like to bring to notice the splendid way the chaps pulled themselves together after a shaky start and being two goals down shortly after the beginning.

Team: H. L. Hodgkinson (*goal*); F. C. H. White, P. M. Wright (*backs*); J. Hunt, W. F. Church, K. W. Hartley (*halves*); E. J. Neill, F. H. McCay, R. H. Francis, J. W. Symonds, A. G. Williams (*forwards*).

CORRESPONDENCE.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—In the report of my address to the Abernethian Society in the January number of the Hospital JOURNAL there are just a few statements that require correction. When referring to intrinsic carcinoma of the larynx, I said a "useful" voice could be established after operation; the voice is rarely a good one. I also said that several cases were men who had bass voices which they had unfortunately produced as tenor voices, so causing friction on the cords, which may have produced malignant disease. I have never seen a true tenor with carcinoma of the larynx. As regards cases of mutism with traumatic origin in the War, I said that, after a period, the voice was ready to return if a correct effort was made, but that the patient tensed the throat muscles to such a degree that it was conceivable that the recurrent laryngeal nerve was strained, but I was very careful to say that I could not prove this and that it was only a surmise.

I am afraid I did not, as reported, class spastic dysphonia as a minor form of speech defect. It is one of the most serious.

In other respects my address was most admirably reported.

Yours faithfully,

London, W. 1;
January 19th, 1929.

CORTLANDT MACMAHON.

REVIEWS.

A TEXT-BOOK OF MEDICINE. Edited by J. J. CONYBEARE, M.D., F.R.C.P. (Edinburgh: E. & S. Livingstone.) Pp. 992. Illustrated. Price 22s. 6d. net.

The Editor remarks that some apology may be deemed necessary for the addition of another text-book of medicine to the large number already available. He is right. The aim is to produce a book which is "small in bulk, low in price, and contains only the essentials of medicine without being anything in the nature of a synopsis."

It may be granted that in this aim the book has succeeded. But to what purpose? In the matter of quick reference it does not compare with Tidy, nor, for the student's purpose, with Woodwork, and it is considerably bulkier than either of these, and treatment is, in most cases, less full.

There are ten contributors, and, as is natural in such text-books, some sections are better than others.

The best is that on the Central Nervous System by Walshe, and this is really excellently done.

The Digestive System by the Editor and the Renal System by Maclean are also good, and the therapeutic appendix to the skin section by Dowling is useful, though the actual section is rather patchy. The respiratory system seems to be very inadequately dealt with, and the student will have to refer elsewhere for much information on this section. The orthodox sequence is followed, starting off with the specific fevers and ending with the nerves and skin.

There are several modern introductions, such as an account of the Plummer-Vinson syndrome, of Fraenkel's line of retarded bone growth, and of Besredka's oral antityphoid vaccine.

There are many omissions. No mention is made of rheumatic mediastinitis; little is said concerning the liver treatment of anaemia; and inborn errors of metabolism are completely excluded.

In considering chlorosis the increased blood volume is overlooked. In purpura hæmorrhagica splenectomy is advocated after removal of septic foci, such as teeth and tonsils; but it is often found that operations just such as these determine a fresh outburst of purpura. Dr. Eustace Smith's treatment with turpentine, which in the majority of cases is entirely successful and obviates any necessity for surgical intervention, is not considered.

In the treatment of diabetic coma the element of shock is not mentioned, and in the diagnosis of acute pancreatitis "pallor" is given as a cardinal sign instead of the more usually accepted "cyanosis."

The English is good, apart from some occasional tautology, e.g. "retina of the eyes," "syphilitic gumma." There are four or five misprints: Beri-beri is due to lack of Vitamin D (p. 324); acute yellow atrophy causes "subscapular" hæmorrhages (p. 629); to

test for iron use potassium ferricyanide and HCl (p. 332); and "potassium iodine" for "potassium iodide" on p. 264.

Apart from these very minor faults the book is excellently produced. The binding is strong, the paper good, and the print exceptionally clear. There are eight plates and sixteen illustrations, an appendix on examination for life insurance, and an efficient index.

A HANDBOOK OF PHYSIOLOGY. By W. D. HALLIBURTON, M.D., LL.D., F.R.C.P., F.R.S., and R. J. S. McDOWALL, M.B., D.Sc., F.R.C.P. (Edin.). (London: John Murray, 1928.) Eighteenth edition. 902 pp. Price 18s. net.

The eighteenth edition of Halliburton's Physiology would have been the thirty-first edition of Kirkes' Physiology if the title had not been changed at the fourteenth edition.

The history of the change is laid forth in an interesting publisher's note at the beginning of the book. As shown here, the direct association of the book with St. Bartholomew's Hospital ceased in 1896, but tradition of the book remains unchanged.

The clarity and soundness of Kirkes and Paget have been replaced by the soundness and clarity of Halliburton and McDowall.

Webster's Dictionary defines a "handbook" as "a manual, or a guide book"; a "text-book" as "a book from which a teacher lectures." "Halliburton" is a handbook.

All the way through the editor's approach of any subject is most skilfully identified with the method of approach of the average student of to-day—no mean achievement for two professors so deeply immersed in modern physiology as are Profs. Halliburton and McDowall.

It is this character which makes the book so popular with students.

As an example of what is meant, the reader is referred to the chapters on reflex action, and Pavlov's work on the conditioned reflexes. Here, as throughout the book, is new and most digestible reading.

There is much that is new in the present edition, in spite of its slightly smaller size. The nervous system, the metabolism of respiration and the blood gases, and chapters bearing on the more fashionable clinical physiology, such as vitamins, gastric hydrochloric acid and isoagglutination—in such subjects is found most of the new material.

But there are many new illustrations and diagrams as well. Indeed, the pictorial side of the book deserves a word of special commendation, which may be extended to the typography, size and general turn-out.

The growth of physiological knowledge demands, and in this case receives, a commensurate development in the handbooks of the subject.

ROENTGENOLOGY: BORDERLAND OF THE NORMAL AND EARLY PATHOLOGICAL IN THE SKIAGRAMS. By ALBAN KÖHLER. Translated by Arthur Turnbull, M.A., Ch.B. (Baillière, Tindall & Cox.) Pp. 556. Plates. Price 42s.

This is a book one is bound to commend highly, because it fills in an excellent manner a much needed gap in X-ray text books, to which it forms a valuable supplement.

In clinical teaching stress is usually laid on the necessity for a sound anatomical and physiological background, and it is from this point of view that Prof. Köhler teaches radiology.

In the first section on bones he speaks as an anatomist, and gradually leads one through to the pathological aspect. By his title he is enabled to ignore the gross lesions, ably described in the current text-books, and proceed to teach the less known and more controversial picture of early and small changes from the normal.

The book contains much valuable information, and where there are controversial points, as there are bound to be in the "borderland" region, the author expresses his own view on that of others with great balance and fairness.

The translation is very good, and there are very few obscure passages. Most of the illustrations are line drawings from radiograms, which are very satisfactory for the demonstration of minor points. Unfortunately the reproduction of radiograms is rather poor, and quite out of keeping with the price and high quality of the book as a whole.

It is a book that is invaluable to a radiologist, and one might also add, to a surgeon.

The number of important, though often little-known facts concerning normal and abnormal appearances, together with the orderly arrangement of the material, makes it an excellent reference book for the latter.

PROTAMINES AND HISTONES. By A. KOSSEL, translated by W. V. THORPE. Monographs on Biochemistry. (Longmans, Green & Co.) Price 9s.

The name protamine was first used by Miescher when working on the chemical nature of the cell nucleus in 1868. He found in the sperm of the salmon a compound of nucleic acid and a base to which he applied this description. The importance of this discovery was not realized as the analogy of the proteins and protamine was not foreseen.

Kossel began his work on these compounds with which this monograph deals in the year 1884, when he described a protein rich in nitrogen found in the red blood cells of the bird, which was in salt-like combination with nucleic acid. To this he applied the term histone. Histone occurs in salt-like combination with nucleic acid in other organs rich in nuclear material such as the thymus gland.

The proof of the close relationship of these compounds with proteins was given by researches on the hydrolysis of a base obtained from sturgeon's sperm. Kossel found that this was not identical with salmon sperm, and proposed that protamine should be a generic name, and that the individual members should be named after the animal or fish in which they occur. He found that hydrolysis of the protamines resulted in the preparation of basic products: arginine, lysine, and histidine, with the addition of valine and proline, and perhaps one or two other α -amino acids. These substances are also found in hydrolysis of normal proteins. The mode of linkage he found also to be the same. Typical proteins are converted into protamines in the course of spermatogenesis.

It is apparent then that the chemistry of the protamines is a part of that of the proteins of which they are really the simplest of a complex series.

The histones have a greater variety in their units of which they are composed, and so approximate more closely to the proteins. The most definite characteristics are their basic content and high arginine content. The grouping is, however, largely arbitrary and depends on the above characters.

The monograph is in the main a review of Kossel's work of which he was the pioneer, and deals with the separation of the components, preparation of the compounds under consideration, and then with their properties and composition. It may be considered to be "descriptive" biochemistry, and as such does not lend itself to review. Kossel realized that the present state of knowledge of these compounds was thus one-sided, and regretted that they had not yet attained significance in "experimental" bio-chemistry. These compounds are constituents of the chief organ of the cell, the nucleus; this organ is closely connected with the processes of cell division, fertilization, and inheritance. It would seem, therefore, that there is a vast field for work in this direction, of which only the fringes have at present been explored.

HOW TO STAIN THE NERVOUS SYSTEM. By J. ANDERSON. (Edinburgh: E. & S. Livingstone, 1929.) Pp. 144. Price 5s. net.

A small, inexpensive book which covers so much ground as this is sure to be of great value to pathologists and laboratory workers. The author has dealt entirely with the processes of fixing, embedding, cutting and staining the nervous system, without discussing the relative value of the staining methods. In other words, it is a book that deals with the practical side of neuro-histology. Throughout the book will be found useful aids and hints in neuro-histological technique, which the author has devised when working in the Pathological Laboratory, Queen Square. Many of the aids described are ingenious, time-saving and extremely useful. The presentation is good and lucid; the *résumés* following each method are distinctly useful.

The methods of staining described are numerous, and undoubtedly the most useful for ordinary routine work. The description of celloidin methods is welcome, especially the preparation and obtaining of serial sections; the methods of staining best adapted to celloidin work are added. Methods of staining frozen sections are well described, and under the heading of "Frozen Sections" will be found the newer methods of staining neuroglia. A chapter devoted to the methods for staining fat, iron and calcium contains methods that have proved successful in the author's hands. All laboratory workers will welcome the pages given up to the preparation of lantern-slides, cleaning dirty celloidin and re-embedding.

The appendix contains the ingredients of the various stains and mordants. It may be said without doubt that this work should be in the library of every pathologist and histologist; further, it should be of great value to the research worker and laboratory

assistants, as it will save them endless trouble, delay and expense. For these reasons alone (if not for many others) this book should be thoroughly recommended.

ELEMENTARY PATHOLOGICAL HISTOLOGY. By W. G. BARNARD. (H. K. Lewis & Co., Ltd.) Pp. 80. Illustrations 176. Price 7s. 6d.

This book should be used in conjunction with a course in morbid histology. It consists of a series of excellent microphotographs illustrating the histological picture in all the common disease processes. Preceding each set of microphotographs is a clear, concise account of the pathological condition to be illustrated and the salient points in each picture are defined. The paper and binding are good.

ERYTHEMA NODOSUM. By J. ODERY SYMES, M.D. (Bristol: John Wright & Sons, Ltd.) Price 5s. net.

As Trousseau—much quoted by the author of this book—said sixty years ago: "Gentlemen, you will only find a few lines devoted to the subject of erythema nodosum in your pathological text-books." The present 70-page monograph inquires into the specific infectious character of the disease by discussing the usual seven epidemiological and clinical points and finds much in his numerous cases to favour this conception.

The aetiology and pathology are carefully studied, Prof. Geoffrey Hadfield having made a thorough examination of nodules, excised at different stages of three cases. His report states briefly that the lesion was an acute and wide-spread arteriolitis of the subcutaneous fat, which appears to be due to a soluble toxin. While giant-cells in large numbers were present in the late stages of an acute infection, there was nothing to suggest that the local presence of the tubercle bacillus accounted for them. No bacteria were ever found.

The relationship to erythema multiforme and the acute rheumatic affections is slight and due in the first case to mistaken diagnosis. The author has excluded from his cases all such as showed a papular, macular or vesicular rash. The important point, he considers, lies in the question of its definite relationship to tuberculosis, so widely advocated on the continent. Parkes Weber (*Brit. Journ. Child. Dis.*, Nos. 244-246, p. 119) gives perhaps the best account of the question in the English literature. That there is some connection the author is convinced, "but to say that E.N. is a tuberculous disease, that it is the exanthem, or the first allergic sign, of tuberculosis, is an exaggeration . . . of the case."

It is interesting that he follows Lendon in attaching importance to phlyctenulæ in diagnosis; and also that he finds his patients much more susceptible to salicylate toxic manifestations than rheumatics. While showing a thorough acquaintance with the literature, the author relies wisely on his own observations on the 250 cases he has seen, both at the Bristol General Hospital and in private practice. His outlook is sane and unprejudiced.

BOOKS RECEIVED.

MINISTRY OF HEALTH: MEMORANDUM ON THE ACCOMMODATION FOR THE SICK PROVIDED AT CERTAIN PUBLIC SCHOOLS FOR BOYS IN ENGLAND. By Capt. W. DALRYMPLE-CHAMPNEYS, M.A., B.M., M.R.C.P.

A POST-OPERATIVE TREATMENT OF EMPYEMA. By CORTLANDT MACMAHON, M.A. (Oxon.). (A reprint from the *St. Bartholomew's Hospital Reports*, vol. lxi, 1928.)

ARTERIAL CARBON DIOXIDE PRESSURE IN CARDIAC DYSPNOEA. By F. R. FRASER, C. F. HARRIS, R. HILTON and G. C. LINDER. (A reprint from the *Quarterly Journal of Medicine*, vol. xxii, No. 85, October, 1928.)

THE ARTERIAL BLOOD IN AMMONIUM CHLORIDE ACIDOSIS. By J. B. S. HALDANE, G. C. LINDER, R. HILTON and F. R. FRASER. (A reprint from the *Journal of Physiology*, vol. lxxv, No. 4, 1928.)

ACKNOWLEDGMENTS.

The British Journal of Nursing—Broadway—Guy's Hospital Gazette—The Hospital Gazette—The Kenya and East Africa Medical Journal—The London Hospital Gazette—Long Island Medical Journal—The Middlesex Hospital Journal—The New Troy—The Nursing Times—The Post-Graduate Medical Journal—The Queen's Medical Magazine—Revue de Médecine—University College Hospital Magazine—The University of Toronto Medical Journal.

EXAMINATIONS, ETC.**University of Oxford.***First Examination, December, 1928.**Anatomy and Physiology.*—Barr-Brown, R. W.**University of Cambridge.**

The following degrees have been conferred :

M.D.—Brewer, H. F., Shaw, W.*M.B., B.Chir.*—Ashby, W. R., Gilchrist, R. M.*B.Chir.*—Bateman, H. F., Janes, L. R., Lloyd Williamson, J. C. F.*Second Examination for Medical Degrees, October, 1928.**Part III. Pharmacology and General Pathology.*—Masina, M. H.*Second Examination for Medical and Surgical Degrees, December, 1928.**Part I. Organic Chemistry.*—Shore, T. L. H.*Part II. Human Anatomy and Physiology.*—Jones, P. W. E., Langford, A. W., Mercer, R. V. F., Roper, R. D.*Third Examination for Medical and Surgical Degrees, Michaelmas Term, 1928.**Part I. Surgery, Midwifery and Gynaecology.*—Forrester-Wood, W. R., Gordon, J. C., Helme, A. C. de B., Hounsfield, M. C., Janes, L. R., McCay, F. H., Neill, E. J., Oakley, W. G., Radcliffe, W., Taylor, H., Thorne Thorne, V., Wright, B.*Part II. Principles and Practice of Physic, Pathology and Pharmacology.*—Bateman, H. F., Elliston, W. A., Francis, C. A., Lloyd Williamson, J. C. F., Palmer, E. A. E., Pimblett, G. W., Underwood, W. E., Ward, F. H.**University of London.***M.S. Examination, December, 1928.**Branch I. Surgery.*—Ross, J. Paterson.*M.D. Examination, December, 1928.**Branch I. Medicine.*—Gaisford, W. F., Sharp, B. B.*Branch VI. Tropical Medicine.*—Leitch, J. N.*First Examination for Medical Degrees, December, 1928.**Passed.*—Carpenter, R. H., Casson, A. H., Chivers, J. A., Cooke, A. Hunt, Hugh, H. C., Kirkwood, R. M., Knight, F. D. W., Reavell, D. C., Smith, M. C. L., Telfer, W. P. McK., Ware, C. E. M.**University of Liverpool.***Diploma in Public Health.*—Chadwick, R. T.**Royal College of Surgeons.**The Diploma of Fellow has been conferred on the following :
Sykes, J. E.**Royal College of Surgeons of Edinburgh.**The Diploma of Fellow has been conferred on the following :
Abernethy, D. A.**Royal College of Physicians and Surgeons.***Diploma in Laryngology and Otology (D.L.O.).*—Ashmawi, M. I.**CHANGES OF ADDRESS.**

CANTI, R. G., 58, Harley Street, W. 1. (Tel. Langham 1534.)

GANE, E., Castle Green, Llansawel, Llandilo, Carmarthenshire.

HORDER, C. A., 4, Boyne Park, Tunbridge Wells. (Tel. 50—unchanged.)

BIRTHS.

ANDERSON.—On January 19th, 1929, at Ribblesdale House, Hornsey, to Ivy ("Billie") (née Bilton), wife of Roy S. Anderson, M.R.C.S., L.R.C.P.—a son.

CRISP.—On January 19th, 1929, at Welton Lodge, Oakham, Rutland, to Joan (née Ainsley), wife of G. H. Crisp, B.M., B.Ch.—a son.

FRANCE.—On January 18th, 1929, at Ludlow, Bromley Common, to Eileen (née Macoun), wife of Francis France, M.B.—a son.

HAMERTON.—On January 10th, 1929, at Canterbury, to Dorothy (née Ruse), wife of J. R. Hamerton, M.B., of Rahere House, Western Esplanade, Herne Bay—a daughter.

LLOYD.—On January 2nd, 1929, at 19, Hereford Square, Kensington, to Antoinette Marie (née Roux), wife of Eric I. Lloyd, F.R.C.S.—a son.

STRUTHERS.—On January 2nd, 1929, to Edith (née Langford), wife of J. A. Struthers, M.B., M.R.C.P., of 36, Fortune Green Road, N.W. 6—a son.

VINES.—On January 5th, 1929, at Wyndyate, Chalfont St. Peter, Bucks, to Molly (née Brindley), wife of H. W. C. Vines, M.D.—a son.

WIGHT.—On December 27th, 1928, to Dorothy, wife of Cecil H. Wight, M.C., M.R.C.S., L.R.C.P., of Wangford, Lowestoft—a daughter.

MARRIAGES.

BALFOUR—CAMPION.—On January 17th, 1929, at All Saints' Church, Alexandria, Egypt, by Rev. Jasper T. Campion, M.A., brother of the bride, assisted by the Rev. J. F. Anderson, M.A., Dr. Ivor H. C. Balfour, son of Mrs. Balfour, Summerlands, Bromley, Kent, to Constance Ruby, elder daughter of Mr. C. A. B. Campion, O.B.E., of 50A, The Avenue, Beckenham, Kent.

PEARSON—CARTMELL.—On January 23rd, 1929, at the Priory Church, Cartmel, Lancashire, by the Rev. W. Heyes, Lawrence Vernon, only son of Dr. and Mrs. M. G. Pearson, of Durban, Natal, South Africa, to Raeburn Lucy, youngest daughter of the late Mr. I. Cartmel and of Mrs. Cartmel, Crosthwaite House, Crosthwaite, Kendal, Westmorland.

DEATHS.

ACTON DAVIS.—On January 22nd, 1929, at Julian Hill, Harrow, George Acton Davis, J.P., for many years Chairman of the Provident Mutual Life and the Peruvian Corporation, Ltd., and sometime acting Treasurer of St. Bartholomew's Hospital, aged 82.

BAKER.—On January 16th, 1929, suddenly, at Elmstead, Andover, Hants, Henry Francis Baker, F.R.C.S., aged 83.

BIRKETT.—On January 19th, 1929, at "Merrilyn," Lee-on-the-Solent, Dr. H. J. D. Birkett.

BURT.—On January 28th, 1929, Harry Vere Burt, only son of Sir Henry Burt, K.C.I.E.

EVANS.—On January 12th, 1929, at his residence, Hampstead House, Seaford, Herbert Norman Evans, M.A., M.B.(Oxon.), formerly of 3, Thurlow Road, Hampstead, aged 93.

LISTER WRIGHT.—On January 4th, 1929, at 4, Lennox Mansions, Southsea, from pneumonia, John Lister Wright, M.R.C.S.E., L.R.C.P., son of the late John Wright, M.D., J.P., of Wynberg, South Africa.

SLOMAN.—On January 8th, 1929, Samuel George, beloved husband of Margaret Sloman, 39, West Street, Farnham, aged 81.

WEBBER.—On January 21st, 1929, at Turleigh House, Bradford-on-Avon, Wilts, William Littleton Webber, F.R.C.S., aged 77.

NOTICE.*All Communications, Articles, Letters, Notices, or Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, E.C. 1.**The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., at the Hospital.**All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone : City 0510.*